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THE
Hampden Hippocrat
MARCH—APRIL 1992

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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DATE: Tuesday, April 28, 1992

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m., SPOUSES ARE WELCOME!

SPEAKER: JOHN EDWIN MROZ, President
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From the Editors

The cover shows the new Wesson Women's and Infant's Unit at Baystate Medical Center. We can all be proud of this state-of-the-art facility, but it's worth remembering that the specialty of Obstetrics and Gynecology in the Greater Springfield area is particularly well-developed. Virtually all subspecialties are available to support the well-trained generalists in the area, many of whom are actively involved in the residency program—(indeed, many came from the residency program!)—which draws outstanding medical students from all over the United States. Assisted fertilization programs, laparascopic surgery, laser surgery, high-risk pregnancy services, and a regional neonatal intensive care program assure that patients can receive care here which is at least as good as that available in cities much larger. Ob/Gyn is particularly well-poised for the new century. ■

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Playing The Game

Medicare. The ultimate four-letter word.

Organized medicine fought its implementation in the 1960's, earnestly believing that eventually the system would fail. As it turns out now, the doom-and-gloomers were correct. Physicians have reaped billions of dollars from a program which, along with Medicaid, began to reimburse them for services that had virtually been given away for many years.

Mark J. Mullan, M.D., President

Not wishing to kill the golden goose, it appears that doctors generally ceased from criticizing the program and were content to accept the status quo in exchange for yearly payment increases. Until now.

In 1992, the proverbial fit is hitting the shan. Everyone is scrambling to learn a new coding system with an absolute and utter lack of information from either the government or the Mediciare carrier. HCFA feels that they have met their requirements for the dissemination of the new regulations, at least for that large number of us who read the Federal Register daily.

I attended one of those meetings with my office manager. There was a fair number of physicians present and many found it quite helpful. The speaker was Patricia Fox, a healthcare management "expert" from Eastern Mass., who was thoroughly professional, obviously knowlegeable and not afraid to say "I don't know" to many of our queries.

In retrospect though, the meeting was exceedingly depressive. Instead of being in the office caring for patients, something which at times like these often seem distantly important, or at an educational seminar trying to improve our abilities to provided a needed service, we spent four hours talking about a ridiculous new system which won't benefit anyone.

We learned about upcoding and downcoding, new definitions for minimal and extensive, low complexity and high complexity. Thank God I now know what an expanded problem focus examination entails. Document, document, document—the key word. If you want to be reimbursed you better have gobs of paper ready for the audit that is going to come sooner or later or else have a wad of cash ready to pay back to Uncle George so that he can pay for his new tax credits and deductions.

The bottom line, as Ms. Fox put so well, is that "this is the game that you have to play" if you wish to survive economically. A depressing thought perhaps, she said, but true.

Well, I for one don't want to play any more games. Naively I always thought that practicing medicine would allow me to pursue a career which would enable me to help those in need in an environment which allowed me the independence and freedom to do the best job possible. Certainly that thought is a pipe dream now. Big Brother is now getting bigger and just beginning to modify, cut, audit and virtually shackle us.

Many would respond that things aren't that bad. The the hot-headed Irishman is just blowing

off his usual steam of frustration (right, Dr. Sterba?). That I'm just afraid of national health insurance. And on and on.

In actuality I'd be happy to get a paycheck from the Feds and run my little shop the best way I could. But in an era of medical care driven by the budget bottom line and not by societal needs, I truly believe that our ability to do the best for patients is going the way of the dinosaur.

Even though most community physicians won't admit it publicly, they are making contingency plans to change their practice patterns in regards to Medicare patients. It can be done quietly in a variety of fashions, from "discouraging" new Medicare patients to becoming a participant in pre-paid health plans that favor a younger population.

Whichever, there clearly are pangs of guilt inside when one even considers shunning elderly patients on Medicare in any way. Our parents, relatives and friends have Medicare. One of my associates is on Medicare. These are good, hard working people who have worked their whole lives helping build a successful society whose fruits we enjoy daily. They certainly are entitled to a peaceful and healthy later life.

But we physicians have become disenfranchised from the process and aren't making the decisions anymore about the kind of health care the elderly receive. And I for one was always taught to do the best I could in whatever endeavor I should pursue—and the process isn't allowing me to do that anymore. So I feel no guilt about these thoughts.

And I am going to change my practice pattern. And I am going to pursue the legalities of withdrawing from the Medicare program while there are other patients out there who I can still care for the way I know best. ■

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Assisted Reproduction Technologies

Halina P. Wiczyk, M.D., the author of the following article, is the Chief of Reproductive Endocrinology at Baystate Medical Center.

Since the 1978 birth of Louise Brown, the field of Assisted Reproductive Technologies (ART) has exploded. No longer considered experimental, the alphabet soup of procedures, In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), and Zygote Intrafallopian Transfer (ZIFT) have become an integral part of comprehensive women's health programs.

"...the ability to treat its many causes has placed (the field of) infertility in the limelight."

Although the incidence of infertility has not increased, awareness of the problem and the ability to treat its many causes has placed this field in the limelight. ART in its various forms has been used to treat absent, blocked, or damaged Fallopian tubes, endometriosis, male factor infertility, and infertility due to immunologic factors, cervical factors, exposure to diethylstilbestrol, as well as unknown causes.

During IVF, controlled ovarian hyperstimulation is performed using an assortment of medications to produce multiple follicles containing oocytes. The patient is monitored closely, with blood estradiol levels and ultrasound scanning. When the follicles are appropriate size, oocyte maturation is completed through the administration of human chorionic gonadotropins; then oocyte retrieval is performed 34-36 hours later using vaginal ultrasound to guide follicle aspiration.

Aspirated follicular fluid is sent to the IVF laboratory which is in close proximity to the retrieval area. There, an experienced team identifies the oocytes, places them in culture medium and then inseminates the oocytes with specially prepared semen obtained from the patient's partner. Fertilization is observed within 24 hours and embryo transfer into the patient is performed approximately 48 hours after the retrieval. The patient continues with hormonal supplementation during the luteal phase. A pregnancy test is performed 12 days after embryo transfer. When a patient becomes pregnant, she is referred back to her obstetrician for continuing prenatal care.

If a patient has normal Fallopian tubes, she can also be a candidate for GIFT or ZIFT. With GIFT, oocytes are retrieved as with IVF, then laparoscopy is performed and gametes (oocytes and washed sperm) are injected directly into the tube. Fertilization occurs within the woman's own tube. The ZIFT procedure allows for placement of embryos directly into the tube at an earlier stage of development. Two days are required, one for oocyte retrieval, and one for zygote transfer 24 hours later. Several programs in this country are performing GIFT and ZIFT transcervically with ultrasound guidance.

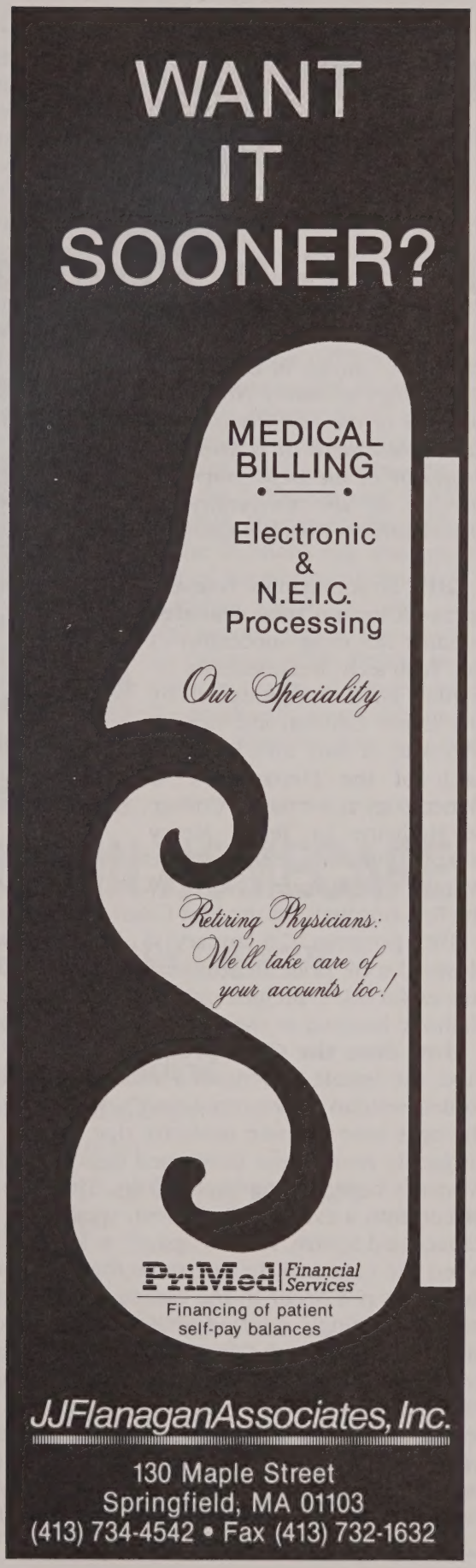
The IVF Registry is a national IVF data collection service established by the American Fertility Society. The Registry reports pregnancy rates as the number of deliveries and ongoing pregnancies divided by the number of transfers performed. The Registry has found that women under 35 years old undergoing IVF have a pregnancy rate of 13-14% while women over 35 years old have a pregnancy rate of 9-10%. The pregnancy rates for these two groups of women undergoing GIFT were 27-28% and 14-15%, respectively.

Counseling and education are fundamental components of any ART program. After a couple has been evaluated by one of the team physicians,

they meet with the nurse coordinator as well as a psychological counselor. Each couple is instructed in the procedure step by step including the home administration of injectable medicines. the counselor looks for any significant problems that would affect a couple's ability to cope during the cycle. Support groups are available to couples to help them through this emotionally and physically demanding period.

Now that these ART programs have been established, new methods are being developed to cope with the complexities of human reproduction. Oocyte donation programs have been very successful in allowing women with nonfunctioning ovaries the ability to have children. Research centers are micromanipulating oocytes to enhance fertilization in cases of significant male factor problems. Partial zone dissection and subzonal insertion techniques have been mastered, allowing fertilization and pregnancy to occur where previously it would have been impossible. Embryos are assisted in hatching in an effort to improve implantation. For those couples where preselection of embryos may be necessary due to genetic abnormalities, blastomere biopsy is being developed.

Access to human gametes has given the field of reproductive endocrinology tremendous information about the intricacies of oocyte development, sperm maturation and function, as well as embryo development. Fertilization rates can be as high as 80%. However, the rate limiting step in ART continues to be implantation. The focus of research is being turned to implantation in hopes of elucidating the mysteries inherent in uterine receptivity. The long range goal will be to identify an infertility problem quickly and be able to treat it successfully within one to two cycles. ■



The Gift Program

Ronald K. Burke, M.D., is the Chief of Gynecology at Mercy Hospital, and the Medical Director of the Fertility and Women's Health Care Center there. He is Associate Professor in the Department of Ob/Gyn at the University of Massachusetts Medical Center.

"On January 15, 1989, Mercy Hospital took pride in announcing that the first successful GIFT pregnancy conceived in a Catholic hospital was born."

GIFT, an acronym for **Gamete Intra-Fallopian Tube Transfer** remains the most successful of the "high tech" treatments for infertility. GIFT was pioneered by Drs. Ettore Cittidini and Vincenzo Abate of Italy and Richardo Asch of the Department of Gynecology at the Baylor College of Medicine in Texas. Mercy Hospital, in cooperation with the Fertility and Women's Healthcare Center (FWHC), was one of the first hospitals on the East Coast to implement a GIFT program. On January 15, 1989, Mercy Hospital took pride in announcing that the first successful GIFT pregnancy conceived in a Catholic hospital in the United States was born.

How does the GIFT procedure work? First, the female undergoes a stimulated "controlled ovarian hyperstimulation" cycle. When the eggs have become perfectly ripe, we surgically remove the developed eggs from the woman's body during laparoscopy. The eggs are placed into a catheter along with washed, capacitated sperm. An "air space" is left between the eggs and the sperm so that fertilization does not occur in the catheter. (This has been endearingly referred to as "the Catholic airspace"). During the same laparoscopic procedure, the egg/sperm loaded catheter is threaded into the fallopian tube and the contents injected directly into the fallopian tube. Unlike *in vitro* fertilization, GIFT permits fertilization to occur in the fallopian tube, as it would normally, rather than outside the body in a test tube. It is this absence of extra-corporeal (outside the body) development that also makes GIFT more philosophically acceptable to numerous religions.

The entire procedure is accomplished at one "sitting", so that patients traveling long distances do not need to return a second time as they do with IVF. In addition, GIFT further reduces expenses, because the need for a costly microbiology laboratory to sustain extra-corporeal (outside the body) growth is eliminated.

How successful is the GIFT procedure? Much ado has been made about fertility "success rates", which mean many things to different people. Some fertility centers too new to have established their own success rates (or with lower success rates than they would care to publish) quote national statistics rather than their own. The first question must be "successful for whom?" In other words, what was the diagnosis for which the procedure was done and were multiple factors responsible for the infertility. Were the procedures for which success rates are being quoted performed because of endometriosis or pelvic inflammatory disease and were there also male factors involved. In addition, what were the ages of the patients in the group for which the success rates were quoted? (The older the patients, in general, the lower the success rates.)

The next aspect of "success" requires knowing just what end-point is being used to define success. "In-vitro" success means that the egg was fertilized by the sperm and divided in the petrie dish. "Chemical pregnancy" means that the pregnancy test was positive and that there were at least two rising human chorionic gonadotropin (HCG) titers. "Clinical pregnancy" may mean either that a heart beat was detected

or the pregnancy has proceeded beyond twelve weeks along with a detected fetal heart beat. "Ongoing pregnancies" is often used to refer to pregnancies which have progressed beyond 26 weeks. Perhaps the most important and least confusing clinical measure is the "live birth rate" which refers to babies actually born. In addition, "success rates" refers to total pregnancies, regardless of how many births per pregnancy. A twin pregnancy, for example, counts as one, not two successes. The Society of Assisted Reproductive Technologies (SART) and the National IVF/ET & GIFT Registry (of which FWHC is a reporting member) have begun to standardize the reporting of success rates and, beginning in 1990, required that all reporting members use a common computer software program so as to ensure uniformity.

The first international Multicenter Study Group, as of October, 1986, reported a live delivery rate for GIFT of 34.4%. The most recent compiled cumulative success rates of all 180 reporting fertility centers collected by the Society of Assisted Reproductive Technologies and the National IVF and GIFT Registry, reported a live delivery rate for GIFT of 22% as compared to a live delivery rate of 14% for IVF. These results were published in the Journal of Fertility & Sterility, Vol 57:15-24, January, 1992 (Mercy Hospital and the FWHC are the only member reporting centers in Western Massachusetts). The GIFT clinical pregnancy rate for FWHC during the period of time covered by the SART reporting period was 36.4% or 4/11 (27.3% or 3/11, including one pair of twins, if a patient terminated pregnancy is discounted), while the live delivery success rate for the same period of time was 18.2% (2/11, including one pair of twins). Nevertheless, success rates vary from year to year and, as we have mentioned, will vary as our indications for performing GIFT change.

Why is GIFT more successful than IVF? Most experts believe it is because GIFT provides an important, delicate step missing in the process of *in vitro* fertilization, namely—the zygote's trip through the fallopian tube. GIFT is more "natural" than IVF. Moreover, the artificial nutrients in which the fertilized egg must grow during the two days of development outside the body may be lacking. Simply put, the laboratory, as of yet, cannot match the natural environment of the fallopian tube. Finally, in IVF, there is the imperfect surgical procedure of placing the delicate, fertilized preembryo into

Continued on next page

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The GIFT Program

Continued from previous page

the uterus following the two day period of extra-corporeal growth.

Who is a candidate for the GIFT procedure? About 10-15% of patients with long-standing infertility are candidates for GIFT. The minimal requirement is that the patient must have at least one normal, open fallopian tube. The followin chart indicates the various reasons for performing GIFT and the respective success rates:

GIFT: INTERNATIONAL COOPERATIVE STUDY
THE FIRST 800 CASES

Results by etiology

	Cases	Clinical Pregnancies	
		No.	%
Unexplained Infertility	499	175	35
Endometriosis	91	35	38
Male Factor	84	15	18
Failed TDI	65	35	54
Periadnexal Adhesions	32	9	28
Cervical Factor	27	4	15
Oocyte Donation	2	2	100
TOTAL	800	275	34.4

An additional, important indication for performing GIFT is the patient with long standing infertility who requires a repeat laparoscopy. In this instance, not only can the underlying problem be diagnosed and possibly treated at pelviscopy but, with a simultaneous GIFT procedure, there is a chance of achieving a pregnancy at the same time.

What are the disadvantages of GIFT? The main disadvantage of GIFT is that, in the event GIFT is not successful, the ability of sperm to fertilize the egg remains an unknown factor. That is why many reproductive endocrinologists recommend proceeding to IVF following one or two unsuccessful GIFT cycles. For the couple's convenience, FWHC currently has affiliations with several outstanding, nationally recognized IVF centers in New Haven and Boston. The complete cycle management is performed in Springfield repuiring the couple to travel to the IVF center only twice, once for the retrieval and once for the transfer.

What are the emotional and economic concerns about GIFT? The emotional stress and anxiety experienced by a couple whose infertility has led them to an advanced reproductive technology (ART) such as GIFT is painful reality which any fertility center must recognize and treat. Any center dealing with ART must have a sensitive, integrted staff of psychologists capable of dealing with the associated neurosis and psychological trauma. Some infertile couples simply need to be given permission that they don't have to try anymore—that they can get on with their lives and concentrate on something else. Although Massachusetts has "compulsory" infertility insurance, such insurance coverage is often inadequate, leaving couples financially as well as emotionally exhausted. Insurance coverage and financial resources must be checked before beginning treatment. Lengthy, expensive hospital stays for multiple, premature births arising from ART treatments can prove equally devastating.

What about the future for GIFT? At Mercy Hospital we have just launched one of the first "trancervical GIFT" programs in the United States. The procedure promises to offer the higher success rates associated with GIFT along with the convenience of not requiring general anesthesia or laparoscopy, thereby reducing the cost even further. In transcervical GIFT the eggs are retrieved transvaginally and then placed into a catheter along with the sperm. The catheter is threaded through a flexible hysteroscope via the vagina and cervix into the fallopian tube and the sperm/airspace/egg mixture injected into the fallopian tube.

Anyone wishing to know more about the GIFT Program should call FWHC at 781-8220 or the Women's Pavilion at Mercy Hospital, 781-9100. ■

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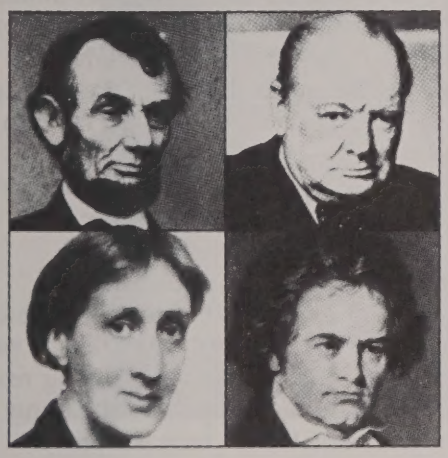

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Recognizing Signs of Child Abuse History in Adult Patients:

Mustering The Courage To Ask

Marla Allisan, J.D., L.I.C.S.W., is an attorney and a psychotherapist. She has prepared this report on the diagnosis of sexual abuse, a topic of concern to all physicians who provide care to women.

"We do know that survivors of child abuse can be helped."

An 8 year-old girl, whom I will call Ellen, struck up a conversation with me at a gathering of her extended family to which I had been invited. I had met Ellen before and found her to be a warm and engaging child. In a quiet moment, later, I realized there had been a persistent theme: she didn't like her divorced mother's new boyfriend and she didn't seem to be able to say why.

When I saw her again, I took her aside and asked her the question I hate to ask: "Ellen, has your mother's boyfriend touched you in any way which makes you feel uncomfortable?" She paused and her big brown eyes widened. Then she gave the answer which I dreaded more than asking the question. "Yes"

The follow up questions were no easier:"What has taken place?" I was calm. Said I believed her. All the right things. One point in sharing this story is that being an attorney and psychotherapist, and one who regularly teaches professionals about child abuse and neglect, does not make asking these questions any easier. "Recognizing" child abuse/neglect calls upon all of us, professionals and lay people alike, to be willing to listen for clues, entertain painful possibilities, ask difficult questions, and hear, as well as respond to, the sometimes excruciating answers.

Many of the patterns seen in child and adolescent disclosure of child abuse are also true for adult survivors whose "detection" may be only a careful question or two away. The unconsciously disguised presentations of many adults may include a host of somatic complaints: their sense that something is wrong "there" may be the only conscious remnant of painful and suppressed experiences (Lowenstein 1990).

A delayed and disguised disclosure is part of what Rolland Summit, M.D. refers to as the child sexual abuse accommodation syndrome. Dr. Summit has identified a common sequence of behaviors exhibited following abuse:

1. Secrecy (the child intuits that s/he will not usually be believed and thus the facts are kept secret; these secrets may be carried far into adulthood);

2. Helplessness (the child feels helpless in the face of more powerful adults; the adult may still feel helpless in relation to former tormentors);

3. Entrapment and accommodation (the child and, later, the untreated adult may find it easier to blame himself than face the terrifying reality of having been at the mercy of ill meaning caretakers. This self blame may lead to a snowballing of personal and medical difficulties);

4. Delayed and unconvincing disclosures (a teenager may angrily announce the abuse lending to confusion in the adult who has heard a statement about victimization);

5. Retraction (referring to the pattern whereby children (and I argue, even adults) may retract or wish to retract what they said out of fear of the consequences of others knowing of the abuse).

I did take Ellen's statement seriously. Her

mother was, initially, in shock and denial. Ellen, frightened of her mother's initial anger, said to me, "I'm thinking of lying." Not only did I think it was the wrong thing to do, but I had lectured so many professionals that children do not, generally, lie about sexual abuse. How could she do this? Calmly, I asked her why, and she admitted to her fears of how others might react. We talked about these fears and then I shared with Ellen a "Quotable Quote" I had just read that morning in Reader's Digest, "Courage is not the absence of fear, it's acting in spite of it." She heard this.

The next day before her scheduled meeting with the District Attorney's Victim Witness Team, Ellen informed me that she was planning to tell the truth. "Oh what led you to change your mind?" I asked. "The Wizard of Oz," she answered cutely. "What?" I asked. "You know," she said giggling, and in a delightful imitation of Bert Lehr, she bellowed, "C-c-c-c-c ourage."

Turning to the perspective of a physician wondering about adult survivors among her/his caseload, what should you be asking and why? It is important to acknowledge that there are many reasons why one might not want to ask patients questions which might yield information about prior abuse and neglect. Your office is likely a busy one and you may have concerns that a patient may want to discuss answers to any questions more than your treatment time or expertise allows. You may have concerns about to whom you might refer this patient if, indeed, they have substantial and unresolved abuse/neglect histories. You may have a fundamental philosophical doubt—is it advisable to stir up issues the patient may have long forgotten? It is particularly important to acknowledge that asking these questions is difficult, hearing the answers may make us feel uncomfortable and there may be times when we simply would rather not know.

There is such social and familial pressure on children, teens and even adults to suppress and keep secret the facts of childhood abuse and neglect that many adult survivors fail to disclose information that could be quite relevant to their psychological and medical care. The many reasons why you will want to ask questions eliciting information about possible abuse/neglect histories include the following:

1. You can make appropriate recommendations and referrals for psychotherapy and/or parent

Continued on next page

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Child Abuse

Continued from previous page

child guidance (especially if the adult survivor is also a parent). Encourage your patient to seek help from clinicians with expertise in this area.;

2. The information may be relevant to providing routine and specialized medical care. For example has your client avoided routine gynecological care even though a DES daughter? Are there particular things which would not be massively inconvenient to your practice that would help an adult survivor feel more in "control" in your treatment of him or her? For example would the patient be comforted by the presence of a second person or friend in the examining room?

3. The child or adult survivor may have civil and criminal legal rights which they have not yet explored; pursuit of legal remedies may even be instrumental in helping them afford the follow up care necessitated by the abuse or neglect;

4. You may be able to help the patient identify current prevention issues. For example are other children at risk of abuse or neglect by the adult who abused or neglected them? You can advise the patient to take steps to protect the children and make a child abuse/neglect report;

5. Patients who respond to unresolved histories of abuse and neglect by finding themselves in repeating patterns of revictimization may be encouraged to seek treatment which may result in prevention of further medical and psychological difficulties.

We do know that survivors of childhood abuse can be helped. Individual therapy can aid survivors who are suffering from disintegration and help survivors who are focused on resolving key sequelae to their acknowledged abuse histories. Psychotherapy also takes time and considerable effort on the part of patients. It may also involve group work aimed at helping a survivor see that compassion for others and self are warranted.

With regard to what a physician might ask, Jean Goodwin, M.D., M.P.H. has a list of ten questions, which, with her kind permission, I repeat here. While it's best to ask these questions in person to afford an opportunity for discussion, perhaps these questions or variations on these themes may be included in standard intake forms:

1. In a conflict, have you ever been pushed or shoved? Hit with a fist, kicked or bitten? Threatened with a weapon?

2. In a conflict, have you ever been pushed or shoved? Hit with a fist, kicked or bitten? Threatened with a weapon?

3. Do you have any scars on your body from someone trying to hurt you on purpose? From you trying to hurt yourself?

4. Have you ever been tied down or locked up?

5. When you were a child, did anyone do anything to you that you though was sexual and that made you feel uncomfortable?

6. Have you ever been hit with an object? What objects?

7. As a child, did you ever worry about the mental state of a caretaker? Run away from home? Think about suicide?

8. Do you have nightmares or bad dreams about something bad that happened to you?

9. Do you ever use drugs or alcohol to get numb?

10. Have you ever tranced out, lost time or left your body?

When your patient answers yes to your questioning about abuse, communicate that you believe him/her, explain that it is a common occurance which, if left untreated and unresolved, can affect many areas. The patient may feel some measure of relief knowing that difficulties in areas such as sexuality, relationships, work life and even somatic complaints may be related and part of a treatable psychological response to earlier trauma.

It is clear that the possible answers to these ten questions may yield information which will be relevant to the medical care of a patient as well as to possible referrals for psychotherapy. If one fears being intrusive in the patient's private life, it may be important to remind oneself that, if indeed, the patient has a history of abuse and/or neglect, the primary intrusions into their personal life have already taken place. Whatever interventions are offered as a result of your queries offer the hope of healing and a better future for your patients. Ultimately it is our receptivity to the information and a willingness to ask straightforward questions as we would about other facts relevant to the patient's care, which will yield this important information and the opportunity for the patient to receive the full care that they need. ■

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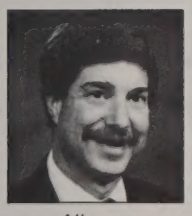

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2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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What About Laparoscopic Hysterectomy?

Leroy Charles, M.D. is a member of Women's Health Group of Springfield, a private practice. He is an expert in Laparascopic hysterectomy, and contributed the following.

Four years ago at Clermont Ferrand, Maurice Bruhat hosted The Second International Congress of Pelviscopy. At least fifty gynecologists from this country were able to participate. The mood was festive, the reception glamorous but most important was the quality of the speakers and presentations which were superb.

Laparascopic hysterectomy is the procedure of the present and the future.

Among the excitement to learn and share was a cry echoed by Jacques Rioux and other famous endoscopists, "How far is too far?"

James Daniell presented a report on the first twenty-six laparoscopic cholecystectomies. Harry Reich, Eric Bouffand and Cameron Neijhart gave the first presentations on laparoscopic-assisted hysterectomy.

Four years later, in November 1991, the American Association of Gynecologic Laparoscopists held a Congress in Las Vegas. Numerous speakers presented their techniques on laparoscopic hysterectomy. A tremendous number of courses are being presented across the country. Advanced laparoscopy training permits us at this time to perform at least 80% of our gynecologic surgeries without a major surgical scar. This facilitates an earlier discharge and speedier recovery.

What is it about laparoscopic hysterectomy? Will this procedure withstand the test of time?

For the past century very few advances have taken place in the technique of hysterectomy. Rutkow documented in the American Journal of Obstetrics and Gynecology a total of 673,000 hysterectomies performed in 1983. More than 3.5 million women underwent non-radical hysterectomies from 1970-1978. It seems that the numbers cited by different authors varies from 600,000 to 700,000 hysterectomies a year. The preferred approach is the abdominal route. At this time, one percent are being performed laparoscopically. Dicker et. al. stated (JAMA 1982) of the hysterectomies performed, 72% were abdominal and 28% were vaginal. The hospital stay was 3 to 7 days and the recovery period 4 to 8 weeks.

C.Y. Liu, M.D. of Chattanooga, Tennessee has performed over 300 laparoscopic hysterectomies. The ideal indications are those cases where abdominal hysterectomy should be performed, in patients with previous pelvic surgeries with adhesions, and in patients with a past history of PID, uterine fibroids, or endometriosis.

Sophisticated video systems enhance visual capabilities. Careful dissection, good knowledge of the pelvic anatomy and constant attention to the course of the ureters are primary conditions for a successful surgery.

Harry Reich distinguished three different modalities of this surgery:

1. The laparoscope is used to assess the pelvis and provide the security that a vaginal hysterectomy can be performed. This is a diagnostic laparoscopy with a vaginal hysterectomy.

2. The laparoscope is used to facilitate adhesiolysis, cut the infundibulo-pelvic, utero-ovarian, and the round ligaments. Then you proceed to a vaginal hysterectomy. Thus the name of laparoscopic-assisted vaginal hysterectomy.

3. When the major part of the operation beyond the uterine vessels is performed laparoscopically, the term laparoscopic hysterectomy is used.

The instruments used are bipolar forceps,

unipolar cautery, CO2 laser, aqua dissection, endo clips and stapling devices. The immediate result is "less bleeding and less pain when compared to those with abdominal and vaginal hysterectomies." Dr. Liu postulated, "There is less tissue reaction to the cauterized pelvic pendicules than to heavy suture materials similar to the case of tubal cautery. Copious and meticulous irrigation in the pelvic area after removal of the uterus and closing of the vaginal cuff may also contribute to the patient's general feeling of well being post-operatively."

The down side of the procedure is the length of operating time. Compared to abdominal hysterectomy (1.5 to 3 hours) and vaginal hysterectomy (1 to 2 hours), laparoscopic hysterectomy in different hands takes 2 to 4 hours. For a busy practitioner this may be a deterrent. It takes time, patience, precise video monitoring and quality instrumentation.

A woman in most instances is more than an equal partner in the household. This must motivate us to consider any option that would decrease morbidity and hospital stay, shorten recovery, and also be cosmetically beneficial.

I am convinced that laparoscopic hysterectomy is the procedure of the present and the future. ■

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Partnership For The Prevention Of Substance Abuse

Over the last year, volunteer physicians and attorneys from Hampden County have been contributing their time and expertise to help combat the substance abuse problems in the community.

Partnership for the Prevention of Substance Abuse is an initiative which pairs a physician and attorney with ten twelve-to-fourteen year old children. An hour is spent discussing experiences, sharing ideas and playing interactive games and exercises.

The program is run as a spring and fall series. The leadership of the Hampden District Medical Society and Hampden County Bar Association chose to focus upon children who are members of Boys' and Girls' Clubs, often the neediest children in the community.

During the last year, the Partnership Program was invited to conduct programs at the Boys' and Girls' Clubs in Chicopee, Holyoke, Springfield (two clubs) and Westfield. To date over one hundren Hampden County children have participated in the program.

Evaluation of the Partnership is underway and is a three-pronged effort. Written surveys are being completed by the facilitators and the Boys' and Girls' Clubs Executive Directors, and focus group sessions are scheduled with the participants.

Though it is premature to make final conclusions, all indications are that the program has been well received by its participants. The Partnership appears to compliment and reinforce information received at the school level. The facilitators have been overwhelmed by the level of knowledge the children have regarding drugs. and alcohol. In addition, the children seem to truly appreciate the contact with the attorneys and physicians.

In an effort to expand the scope of the program, the Bar Association of Hampshire and Franklin County have been approached. The next goal of the program is to develop the Partnership into a regional, three-county program.

If you are interested in volunteering to be trained as a facilitator, or would like more information on the Partnership, please contact me at the West Central Regional Office, 1-800/522-3112. ■

Kerin L. Milesky
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Hampden Committee Activities

Alfred G. Garcia, M.D, brings us up to date on recent activities of our society.

The Executive Committee met on January 21, 1992.

Invited guests included Ms. Joan Paris, seat belt education specialist for the Springfield Health Department and Dr. Daved Whitehouse, Medical director of the Charles River Hospital West.

Ms. Paris presented statistics and reviewed the current seat belt law with the Committee. Dr. Cahill discussed a proposed resolution to reinstate the Seat Belt Law and presented this to the membership at the January 28th District Meeting.

Dr. Whitehouse presented the committee with an overview of the Charles River Hospital West. This hospital is a new psychiatric facility to Western Mass.

The second House Calls program series will be held on Sunday, March 29th. The program will cover the subject of Gastroenteology and will run from 7 p.m. to 8 p.m. on Channel 22. Calls will be taken through 10 p.m. by physician volunteers. In June, the area of Oncology will be on tap for discussion.

A letter written by Dr. Richardson, of the Mass PRO, to Dr. Mullan requested names of members who would be willing to serve on a new Physician Relations Committee. The Committee would meet quarterly for 2 to 3 hours in different locations in the state.

Dr. Murray Watnick proposed a Task Force to review the health crisis and draw up a report for the membership. Dr. Watnick presented this to the membership at the District Meeting on January 28th.

The Poster contest will be held in March with the Awards Ceremony moved up a month to May. Merrill-Dow will again provide the savings bonds for the children.

Dr. Robert Goodman resigned as Secretary of the Society and Dr. Garcia will assume the post. Dr. David Chadbourne accepted the Assistant Secretary seat.

The Medico-Legal Committee met on January 9, 1992. The meeting was co-chaired by Dr. Francis Murray and Attorney John Bagley of the Hampden County Bar Association.

Dr. Mullan presented a brief background on this committee and on his discussions with Attorney Robert Gordon, President of the Bar Association.

The Role Model Program in the Springfield School system was discussed. The Bar Association is at present working with the School Department and would like to have doctors and lawyers work together and talk to the students.

Problems arising for both doctors were discussed, especially problems with reports required from doctors. Dr. Linson suggested that doctors should be educated as to what is an adequate report, what some of the legal terminology means and what is a reasonable fee for the report.

Another problem exists when a trial is called ahead of the regularly scheduled date and the physician must appear with little or no warning.

Attorney Fitzgerald suggested a sub-committee could be formed of both doctors and lawyers which could sit down with the judge and ask for consideration in making a convenient date for all parties involved.

Lien letters were also discussed. These letters come from some doctors and generally state that the letter must be signed to secure the physician's right to get the bill paid. All attorneys thought the letters were proper because they put the doctor in line for his share of any settlement in payment of the bill.

Drs. Murray and Mullan will send questionnaires to the physicians asking what type of information would be helpful to them.

The Medico-Religious Committee met on January 6th. Professor Joseph M. Healy, J.D. of the Department of Community Medicine and Heath Care at the University of Connecticut Health Center, will be the main speaker at the October 14th Medical Ethics Seminar.

Further discussion centered on the Massachusetts Catholic Conference's recent paper entitled, "The Health Care Proxy Bill: A Catholic Guide".

The Ethics Committee at Mercy Hospital has written to the Conference stating disagreement with wording regarding nutrition and hydration. A copy will be distributed to the Massachusetts Medical Society for their thoughts ■

Traffic Safety and Public Health:

A United Way

Joan D. Paris is the Regional Occupant Protection Coordinator at the Springfield Public Health Department.

The National Highway Traffic Safety Administration states that, "Every ten minutes, 24 hours a day, 365 days a year, another American is killed in a motor vehicle crash, and every ten seconds a person is injured." Massachusetts residents contribute two people daily to the yearly death toll.

Motor vehicle crashes are the leading cause of death for Americans 34 years old and younger.

Motor vehicle crashes are the leading cause of death for Americans 34 years old and younger. It is a significant cause of death across all ages. Comparative studies demonstrate that no illness or other accident causes as many deaths or life-long handicaps. One out of every three people will be in a serious accident in their lifetime and the entire population can expect to be in an accident once every ten years.

Department of Transportation statistics and hospital trauma reports reveal that safety belts reduce motor vehicle fatalities by 40-50% and serious injuries by 45-55%. Statistics show that premature death and disability continue to steepen the annual morbidity and mortality data. Injury prevention education as it relates to motor vehicle crashes needs to penetrate the masses.

The need for this education began with the first recorded traffic fatality in the United States. A passing motor car struck and killed a New York real estate dealer in September 1899. In the years between 1910 and 1985 there would be more than 2.5 million traffic related deaths. In 1990 motor vehicles caused 44,000 deaths in the United States.

A recent national study on the efficacy of seat belt use found that safety belt use reduced hospital admissions from crashes by 65% and hospital charges by 67%. Routine seat belt use would save more than 17,000 American lives annually.

A car crash at a vehicle speed of 45 M.P.H. is equitable to a free fall from a five story building. The crash force would cause body weight to increase four times greater than original body weight. As the vehicle travels from 45 M.P.H. to 0 M.P.H. in one-tenth (1/10) of a second, the unbelted occupant continues to travel at 45 M.P.H. Within one-fiftieth (1/50) of a second after the car has stopped, the unbelted person hits the dashboard or travels through the windshield. A vehicle lap belt would keep the occupant from being ejected from the car. A vehicle shoulder harness would protect the face and head from dashboard or windshield injury. This three-point harness further protects the chest from crushing the steering wheel. The vehicle collision can't always be avoided. The human collision which occurs about 0.02 seconds after the first collision can be abbreviated.

Saving lives is an arduous task. As early as 1914 the newly established National Safety Council advised the multidisciplinary approach of engineering, enforcement and education. In 1920, President Hoover convened a national conference that would prevent collisions. Crash survival design engineering began in 1942. Hugh DeHaven, a World War II plane crash survivor, pioneered efforts that would distribute crash forces and enhance survival.

The medical profession has been prominent in traffic safety issues since 1930. Dr. Claire Straith, a Detroit plastic surgeon, installed safety belts and padding in his own car to reduce injury

on impact. Dr. Straith was followed by John Stapp, a physician and biophysicist, who simulated crash forces on a rocket-propelled sled to test safety belts. In the 1950's the American Medical Association and American College of Surgeons worked toward the mandatory installation of safety belts. By the mid-1950's a mutidisciplinary effort toward increased traffic safety was well established. Researchers, engineers, public safety, and public health officials documented evidence that ultimately led to federal regulation of the automobile industry. The National Highway Traffic Safety Administration was established in 1966. Dr. William Heddon, Jr. was appointed NHTSA's first administrator in a symbolic endeavor to unify traffic safety and public health in a single community.

Physicians and public health educators are well poised in the community to align traffic safety messages with routine medical care. Providing literature, sharing expertise, and supporting traffic safety groups are effective interventions.

The collaborative intervention of legislation/enforcement, education/behavior change and intervention/technology have long been identified as the means toward a realistic solution. The vehicle safety problem is clear. The suggested preventions are reasonable.

We need only to network ourselves as the human aspect or applied prevention as frequently as we can in the communities in which we live. ■

Editorial Comment

One of the jobs of an editor is to figure out what to do with spaces like this which don't quite fit anything.

Let us take this opportunity to point out that it takes no great talent to write short pieces for the Hippocrat, and believe us, we could use some additional editorial help. If you would like to volunteer, you may select from any of the following titles: *co-editor; sports reporter; society reporter; political commentator;* or, if you have an artistic bent, *editorial cartoonist.*

In addition to having a title, you could be the guest editor of a whole issue—as you have guessed, we are working our way through the specialties, subspecialties, and other interest groupings, and you have probably already noticed that you could do a much better job than we do. We don't disagree. This is your chance! We're waiting for your call. ■

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New Members Welcome

Neil R. Connelly, M.D.
Springfield Anesthesia Service
333 East Columbus Avenue
Springfield, MA 01105

Born: September 30, 1961
Premed: Fairfield University, Connecticut 1979-1983
Medical: State University of New York, Syracuse 1983-1987
Internship: St. Raphael Hospital, Connecticut 1987-1988
Residency: Yale 1988-6/91
Specialty: Anesthesiology

James L. Frank, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: January 20, 1956
Premed: Brown University, Rhode Island 1974-1978
Medical: University of Cincinatti 1979-1983
Internship: Allegheny Hospital, Pennsylvania 1893-1984
Residency: Allegheny Hospital, Pennsylvania 1984-1988
Fellowship: Medical College of Virginia 1988-6/9
Specialty: General Surgery/Oncology

Elliot B. Greenberg, M.D.
2 Medical Center Drive
Suite 512
Springfield, MA 01107

Born: September 24, 1956
Premed: Indiana University 1975-1980
Medical: Hahnemann University, Pennsylvania 1980-1984
Internship: Vanderbilt University, Tennessee 1984-1985
Residency: Vanderbilt University, Tennessee 1985-1988
Specialty: Obstetrics/Gynecology

Scott S. Reuben, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: June 12, 1958
Premed: Columbia College 1976-1980
Medical: State University of New York, Buffalo 1981-1985
Internship: State University of New York-Buffalo Affiliated Hospitals 1985-1986
Residency: Mt. Sinai Medical Center 1986-1988(Anesthesiology)
Fellowship: Mt. Sinai Medical Center 1989-1990 (Anesthesia and Pain Management)
Specialty: Anesthesiology

David W. Deaton, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: August 3, 1956
Premed: Davidson College, North Carolina 1974-1978
Medical: Duke University School of Medicine 1979-1983
Internship: University of Chicago 1983-1984
Residency: University of Chicago 1984-1988
Fellowship: University of Chicago 1988-1990
Specialty: Cardiothoracic Surgery

Wandana Joshi-Ryzewicz, D.O.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: May 19, 1960
Premed: College of the Holy Cross 1977-1981
Medical: New England College of Osteopathic Medicine 1982-1986
Internship: Osteopathic Hospital of Maine 1986-1987
Residency: University of Massachusetts Medical Center 1987-1990
Specialty: Anesthesiology

Continued on next page

New Members Welcome

Continued from previous page

Paul J. Owens, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: June 17, 1958
Premed: Holy Cross College 1976-1979
Medical: Georgetown University 1979-1983
Internship: Bethesda Naval Hospital 1983-1988
Morristown Memorial Hospital, New Jersey 1987-1988
Residency: Morristown Memorial Hospital 1988-1990
Fellowship: Baystate Medical Center 1990-Present
Specialty: Internal Medicine/Cardiology

John R. Waterman, M.D.
50 Maple Street
Springfield, MA 01103

Born: April 6, 1946
Premed: University of Massachusetts 1964-1968
Medical: University Of Vermont 1968-1972
Internship: Wilford Hall, USAF Medical Center, Texas 1972-1973
Residency: Wilford Hall, USAF Medical Center, Texas 1973-1975
Fellowship: Johns Hopkins University 1976-1978
Specialty: Internal Medicine/Rheumatology

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Doctor: your patient has applied for insurance benefits. He/she will not receive a penny unless you fill out the following form completely. Even if you filled out a similar form for us last month, we have probably lost or destroyed it.

PATIENT'S NAME _____
ADDRESS: _____
PHONE NUMBER: _____
SOCIAL SECURITY NUMBER: _____ CAR LICENSE NUMBER: _____
OCCUPATION: _____ SPOUSE'S OCCUPATION: _____
ANNUAL SALARY, AFTER TAXES AND CHARITABLE CONTRIBUTIONS: _____
SPOUSE'S MAIDEN NAME: _____
NUMBER AND AGES OF CHILDREN: _____
(Use separate forms if necessary)
ETHNIC BACKGROUND: _____ FAVORITE FOOD: _____
ANY PETS? *(Exclude birds, goats, starfish)*: _____

Current Illness: *(Use 1991 revised ICD9 codes with decimal modifiers only)*

_____
DATES OF SERVICE: _____
ARE YOU STILL CARING FOR THIS PATIENT?: _____
IF SO, WHY?: _____
IF NOT, WHY NOT?: _____
IF NOT, WHO IS?: _____
HOW DOES THIS MAKE YOU FEEL?: _____
HAS PATIENT RECOVERED FROM THIS ILLNESS?: _____
IF NOT, WHEN DO YOU EXPECT RECOVERY *(exact date)*: _____
IF PATIENT IS NOT EXPECTED TO RECOVER, GIVE EXACT DATE OF FUTURE DEMISE: _____
Please enclose original x-rays, pathology slides, blood samples, or any other material used to make the diagnosis.
DID YOU MAKE THE DIAGNOSIS?: _____
HOW SURE ARE YOU?: _____
IF YOU DID NOT, WHO DID?: _____
WHEN DID HE/SHE GRADUATE FROM MEDICAL SCHOOL?: _____
LIST JOURNALS TO WHICH HE/SHE SUBSCRIBES: _____
(Use separate form, if necessary)
DO YOU AND HE/SHE GET TOGETHER SOCIALLY?: _____
IF NOT, WHY NOT?: _____
Please list all physicians, dentists, chiropractors, podiatrists, and pharmacists who have served this patient during the past twenty years. Give dates and diagnoses, using 1991 ICD9 codes with decimal modifiers. Use separate form if necessary.
IS THE PATIENT, HIS/HER SPOUSE, PARENTS, OR CHILDREN INSURED BY ANY OTHER COMPANY?: _____
If so, send duplicates of their insurance form to us. Copies are not acceptable: They must be filled out again.
DO YOU HAVE ANY SECRET VICES?: _____
IF NOT, WHY NOT?: _____
WHAT IS YOUR CURRENT BLOOD CHOLESTEROL? *(Must have been taken within 30 days)*: _____
DO YOU OWN A BOAT?: _____
NAME THE MINISTER OF TRANSPORTATION IN GREAT BRITAIN: _____
WHO IS YOUR FAVORITE CELEBRITY? *(Note: do not include Madonna or Zubin Mehta)*: _____
WHY?: _____
(Use seperate form if necessary)
IS ANYONE CURRENTLY THINKING ABOUT SUING YOU FOR MALPRACTICE?: _____
IF SO, ARE YOU GUILTY?: _____
HOW CAN YOU LIVE WITH YOURSELF TAKING MONEY FROM SICK PEOPLE?: _____
(Use seperate form if necessary)

On a seperate form, write a 1,000 word essay (100 words if you are a surgeon) explaining in detail why you should get paid for your services to this patient.

YOUR FULL NAME: _____
YOUR LAST NAME AND FIRST TWO INITIALS: _____
YOUR SOCIAL SECURITY NUMBER: _____
YOUR SIGNATURE: _____
YOUR ADDRESS: _____
YOUR BUSINESS PHONE NUMBER: _____ YOUR HOME PHONE NUMBER: _____
PHONE NUMBER WHERE YOU CAN BE REACHED WHEN NOT AT WORK OR AT HOME: _____
YOUR MATERNAL GRANDMOTHER'S MAIDEN NAME: _____
TODAY'S DATE: _____ YESTERDAY'S DATE: _____

NOTE: If you have answered any of the above questions falsely, you will be prosecuted to the full extent of the law.
NOTE: We forgot to tell you to use a number two pencil to fill out the form. If you used anything else, you will have to start over.
NOTE: Make several copies of this form, since we usually lose the first three or four you send in.
NOTE: If we decide to pay, we will send the money to your patient, who will then pay you, probably.
NOTE: Please enclose a check or money order for $25.00 for processing this form.
NOTE: If we decide to pay you, 10% of the money will be contributed to the Ted Kennedy Ethics in Medicine Foundation, unless you check one of the following:

A. ☐ I am a greedy pig
B. ☐ I don't care about ethics in medicine
C. ☐ I know some things about Ted Kennedy that the National Enquirer would pay good money for
D. ☐ I am basically against the American Way

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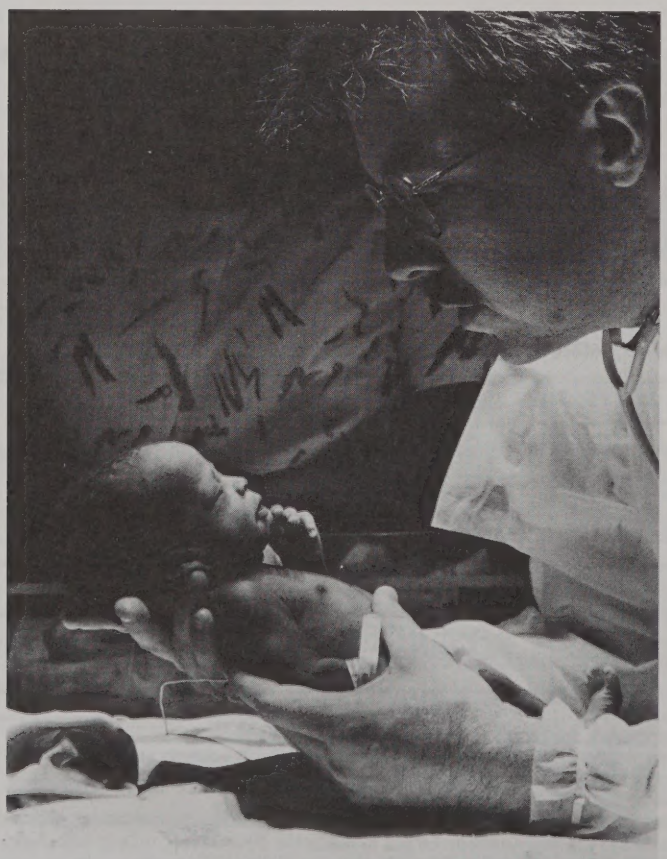

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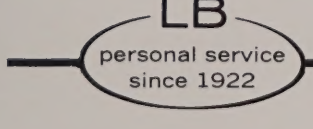

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T	F	
☐	☐	Coding, billing and reimbursement are our easiest tasks
☐	☐	Adjusting to RBRVS was easy
☐	☐	We enjoy maintaining multiple sets of procedure codes
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